TEXT OF PROPOSED CHANGES
TO THE REGULATIONS OF THE
DIRECTOR OF THE DEPARTMENT OF MANAGED CARE

DATED: August 7, 2000

1. Amend Section 1300.68 to read:

1300.68. Grievance System.

Every health care service plan shall establish a ~~A plan~~ grievance system ~~established~~ pursuant to the requirement of Section 1368 of the Act~~. shall include at least the following features:~~

(a) The grievance system shall be established, pursuant to written procedures, for the receipt, handling and ~~disposition~~ resolution of complaints within 30 calendar days of receipt by the plan, or the entity contracted by the plan to administer its grievance system.

(b) The plan's grievance system shall include at least the following features.

(1) An officer of the plan shall be designated as having primary responsibility for the maintenance of such procedures and for the review of their operations and for the utilization of any emergent patterns of grievances in the formulation of policy changes and procedural improvements in the plan's administration whether or not the plan administers its own grievance system or delegates its authority to resolve grievances to another entity.

~~(b)~~(2) At least one telephone number for the filing of complaints shall be located within each service area including facilities of providers which are used by the plan. The locations for filing complaints and telephone numbers and related procedures regarding grievances shall be communicated in writing to enrollees and subscribers.

~~(c)~~(3) As to each complaint received in person or by telephone at a grievance location, a written record shall be made, including the date, identification of the individual recording the grievance, and disposition. A written record of tabulated grievances shall be reviewed periodically by the governing body of the plan, the public policy body created pursuant to Section 1300.69, and by an officer of the plan or his designee, and the review procedure shall be documented, including documentation of the procedure or mechanism used in consideration of tabulating grievances periodically in relation to policy and procedure review.

~~(d)~~(4) At each grievance location, assistance shall be provided in the filing of grievances. A "patient advocate" or ombudsperson may be used.

~~(e)~~(5) Complaint forms and a copy of the grievance procedure shall be readily available at each facility of the plan and the plan shall provide them to subscribers and enrollees promptly upon ~~receipt of a~~ request.

~~(f)~~(6) The plan shall assure that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) solely on the grounds that the enrollee filed a complaint.

~~(g)~~(7) A grievance system shall provide (1) for the acknowledgement of the receipt of a complaint and notice to the complainant of who may be contacted with respect to the complaint within ~~20~~ five (5) days, and (2) for notice and a written statement to the complainant of the disposition or pending status of the complaint within 30 days of the plan's receipt of the complaint. Where the plan is unable to distinguish between complaints and inquiries, they shall be considered complaints.

~~(h)~~(8) A grievance system shall provide for a prompt review of complaints by the management or supervisory staff responsible for the services or operations which are the subject of the complaint.

(9) Copies of grievances and responses that the plan is required to maintain for five years, shall include a copy of all medical records, documents, evidence of coverage and other relevant information upon which the plan relied to reach its decision.

(10) The grievance system shall include procedures for the expedited review of grievances for cases involving imminent and serious threat to the health of the enrollee, and shall include the elements set forth in Rule 1300.68.01.

(c) Department review of grievances.

An enrollee may submit a grievance to the Department for review, after completing the plan's grievance process or after having participated in the plan's grievance system for 30 days; however, this requirement shall be waived if the Department determines that an earlier review is necessary. Upon receipt of such grievance, the Department shall notify the plan, and the plan shall submit within five (5) calendar days after receipt of the notification, the following information:

(1) The plan's response to the issues raised by the enrollee's complaint filed with the Department.

(2) A copy of the plan's response to the enrollee's grievance filed with the plan.

(3) A complete and legible copy of any and all medical records related to the grievance.

(4) A copy of the cover page of the applicable evidence of coverage and other relevant pages of the evidence of coverage with the specific sections pertaining to the enrollee's grievance underlined.

(5) Any other relevant information that the plan used to reach its decision.

(6) Any other information that the plan believes is relevant to the resolution of the grievance.

(7) If the plan did not use medical records or did not rely upon any information other than the evidence of coverage to make its decision, the plan shall so state in its response to the Department.

The Department may request additional information or medical records from the plan. Should additional information be requested, the plan shall submit this information within five (5) business days of receipt of the Department's request.

Any delay caused by the plan's failure to submit the requested information may result in the Department ruling in the enrollee's favor on any issue that the Department cannot decide without the information in question.

~~(i)~~(d)(1) The quarterly report required by subdivision (c) of Section 1368 of the Act shall include complaints filed by enrollees that are pending and unresolved for 30 days or more within the plan's grievance system. When a plan's grievance system provides one or more opportunities for appeal, an enrollee's complaint shall be included in the plan's quarterly report until the enrollee has exhausted all opportunities for appeal or the time for appeal under the grievance system has expired. The quarterly report shall not include complaints filed and/or processed outside the plan's grievance system in other complaint resolution procedures, such as arbitration, voluntary mediation, the Center for Health Care Dispute Resolution, an independent review organization, the Medi-Cal Fair Hearing Process or ~~and~~ the Department of Managed Care (Department of Managed Health Care) ~~of Corporations~~.

(2) A plan that has no complaints within the plan's grievance system that are pending and unresolved for 30 days or more shall file the quarterly report required by subdivision (c) of Section 1368 of the Act notifying the Department of that fact.

(3) The quarterly report shall be prepared for the quarter ending on March 31st, June 30th, September 30th and December 31st of each calendar year, and shall include complaints pending and unresolved for 30 days or more during the quarter. The quarterly report shall not contain personal or confidential information with respect to any enrollee.

(4) The quarterly report shall specify the licensee's name, quarter and date of the report, categories reported, type of grievance system based on levels of appeal, and a breakdown of the total number of pending and unresolved complaints for each category and for each level of the plan's grievance system. The breakdown shall include the number of complaints for each corresponding reason specified in the report. If complaints are pending and unresolved for reasons other than reasons specified in the quarterly report, those other reasons shall be specified in the report together with the corresponding number of complaints for each reason. If a grievance system provides two or more levels of appeal, each level shall be separately listed in the report and shall include the same information required by the report for First-Level Appeals.

(5) The quarterly report shall be signed by a person authorized to do so by the plan, verified, and filed along with two copies of the quarterly report, in the Department's Sacramento Office to the attention of the ~~Health Plan Division~~ Filing Clerk no later than 30 days from the close of the quarter. The quarterly report need not be filed as an amendment to the plan application.

(6) The quarterly report shall be filed in the format specified below:

STATE OF CALIFORNIA
DEPARTMENT OF ~~CORPORATIONS~~ MANAGED CARE

QUARTERLY REPORT OF
PENDING AND UNRESOLVED GRIEVANCES
PURSUANT TO HEALTH AND SAFETY CODE
SECTION 1368(c)

1. Name of Licensed Health Plan (as appearing on license):
_____

2. Report for Quarter Ending: _____

3. Categories of Complaints Included in this Report: (Include total plan enrollment for each category.)

Category	Enrollment

( ) Commercial _____
( ) Medicare (Risk) _____
( ) Medicare (Supplement) _____
( ) Medi-Cal _____

4. Type of Grievance System Based on Levels of Appeal Allowed by Plan:
( ) Initial Complaint Only (No Appeal Allowed)
( ) One-Level Appeal (One Appeal Allowed)
( ) Two-Level Appeal (Two Appeals Allowed)
( ) Multi-Level Appeal (Three or More Appeals Allowed)

5. Breakdown of number of pending and unresolved complaints for each category and each level in the grievance system, as follows:

Category: _____

INITIAL COMPLAINTS

Number of Complaints	Reasons
_____	Pending additional information from enrollee.
_____	Pending additional information from provider.
_____	Pending plan's review and determination.
	Other Reason(s) (Specify):
_____	a. _____
_____	b. _____
_____	c. _____
	(Continue, if necessary)
_____	TOTAL INITIAL COMPLAINTS

FIRST-LEVEL APPEALS

Number of Complaints	Reasons
_____	Pending receipt of any appeal filed by enrollee.
_____	Pending additional information from enrollee.
_____	Pending additional information from provider.
_____	Pending plan's review and determination.
	Other Reason(s) (Specify):
_____	a. _____
_____	b. _____
_____	c. _____
	(Continue, if necessary)

_____ TOTAL FIRST-LEVEL APPEALS

[NOTE: If the Grievance System provides two or more levels of appeal, each level shall be separately listed, and shall include the same information required by the report for First-Level Appeals.]

_____ TOTAL NUMBER OF COMPLAINTS FOR THIS CATEGORY

[NOTE: List breakdown for next category of complaints marked in Item 3. as set forth in Item 5.]

VERIFICATION

I, the undersigned, have read and signed this report and know the contents thereof, and verify that, to the best of my knowledge and belief, the information included in this report is true.

By: _____
(Signature of Individual Authorized to Sign on Behalf of the Plan.)

Name: _____
(Typed or Printed)

Title: _____

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference cited: Section 1368, Health and Safety Code.

2. Adopt Section 1300.68.01 to read:

1300.68.01. Expedited Review of Grievances.

(a) Every plan shall include within its grievance system, procedures for the expedited review of grievances involving an imminent and serious threat to the health of the enrollee ("urgent grievances"). At a minimum, plan procedures for urgent grievances shall include the following:

(1) The plan shall immediately notify the complainant of his/her right to notify the Department of the grievance.

(2) The plan shall provide the complainant and the Department with a written statement on the disposition or pending status of the urgent grievance within three (3) days of receipt.

(3) The enrollee's medical condition shall be considered by the plan when determining the response time.

(b) The plan shall establish a system that provides for receipt of Department contacts regarding urgent grievances twenty-four hours a day, seven days a week. During normal business hours, the system shall provide for the plan to contact the Department within thirty (30) minutes following Department contacts regarding urgent grievances. After normal business hours, on weekends or holidays, the system shall provide for the plan to contact the Department within one (1) hour following Department contacts regarding urgent grievances.

The system established by the plan shall provide for the availability of a plan representative with authority on the plan's behalf to resolve urgent grievances and authorize the provision of health care services covered under the enrollee's plan contract in a medically appropriate and timely manner. Such authority shall include making financial decisions for expenditure of funds on behalf of the plan without first having to obtain approval from supervisors or other superiors within the plan. Nothing in this subsection shall restrict the plan representative from consulting with other plan staff on urgent grievances.

(c) Plans shall provide the Department with the following information with respect to plan procedures for urgent grievances:

(1) A description of the system established by the plan pursuant to subsection (b).

(2) The description shall include the system's provisions for scheduling qualified plan representatives, including back-up plan representatives as necessary, to be available twenty-four (24) hours a day, seven days a week to respond to Department contacts regarding urgent grievance representatives. Provisions for scheduling shall include the names

and titles of those plan representatives who will be available under the system, their telephone numbers, and, as applicable, pager numbers, answer service numbers, voice-mail numbers, e-mail addresses, or other means for contact.

(3) The description shall provide the Department with information on how to access the system established by the plan.

(4) If the plan revises the system established pursuant to subsection (b), the plan shall notify the Department at least thirty (30) days in advance of implementing the revisions.

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1368 and 1368.01, Health and Safety Code.